MEDICAL POLICY STATEMENT
TrueCare

Policy Name & Number	Date Effective
Non-Emergency Facility to Facility Transfers-TrueCare-MM-1449	07/01/2025-04/30/2026
Policy Type	
MEDICAL	

Medical Policy Statements are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Non-Emergency Facility to Facility Transfers

B. Background

This policy addresses the necessity of transferring a patient to a second acute care facility (receiving facility) when the individual requires care not available at the original facility. The goal of any transfer is to maintain the optimal health of the patient. This is accomplished by transferring the patient to the nearest facility that provides the highest specialized care needed.

Inter-hospital patient transfer is an important aspect of patient care, most often to improve patient management. During such transfers, there must be continuity of medical care. Key elements include the decision to transfer and communication, pre-transfer stabilization and preparation, choosing the appropriate mode of transfer, personnel accompanying the patient, equipment and monitoring required during the transfer, and documentation and handover of the patient at the receiving facility.

Transfer, admission, and subsequent care to the receiving facility is not medically necessary when the needed care is available at the originating facility.

C. Definitions

- **Non-Emergency** – A situation for which immediate response is not needed for the provision of medical treatment.
- **Inter-Facility Transfer** – The transfer of patients between 2 healthcare facilities.
- **Intra-Facility Transfer** – The transfer of patients within the same facility.
- **Originating Facility** – The current facility to which an individual has been admitted for care and from which a transfer is planned.
- **Participating (In-Network) Facility** – Facility that is contracted with TrueCare.
- **Non-Participating (Out-of-Network) Facility** – Facility that is not contracted with TrueCare.
- **Receiving Facility** – The facility to which a transfer is planned.

D. Policy

I. The following non-emergency transfers require a medical necessity review:
   A. A non-emergency transfer from a participating inpatient facility to a participating inpatient facility that is not within the same healthcare system.
   B. A non-emergency transfer from a non-participating facility to a participating facility.
   C. A non-emergency transfer from a non-participating facility to a non-participating facility.

II. For non-emergency transfers that require a review of medical necessity, the receiving facility submits the review of medical necessity request to TrueCare.

III. Requests for transfers that require a review of medical necessity must meet the following criteria:

A. Member must be medically stable for transfer and 1 of the following:
   1. Member requires transfer to a level of care which is not available at the originating facility.
   2. Member requires transfer for a medically necessary diagnostic or therapeutic service which is not available at the originating facility.
   3. Member requires transfer for services of a specialist to evaluate, diagnose, or treat their condition when that specialist is not available at the originating facility.
   4. Member requires transfer because member has received care at a specific prior institution for a condition not normally managed at the originating facility and return to that prior institution is needed to diagnose, manage, or treat a complication or other acute issue.
   5. Member requires transfer to improve the health and welfare of the member (ie, parental bonding).
   6. Transfer to allow a parent who gave birth to remain with the neonate is considered medically necessary when the neonate transfer meets the medically necessary criteria listed above and the parent who gave birth requires continued hospitalization due to birth complications or other medically necessary conditions.

IV. The following non-emergency transfers do not require a review of medical necessity:
   A. Inter-facility transfers within the same healthcare system.
   B. Intra-facility transfers within the same facility.

V. Non-emergency (elective) transfers are not a covered service for the following:
   A. The criteria above have not been met.
   B. The transfer is for the convenience of the member, the member's family, the physician, or the originating facility.

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	03/12/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	07/01/2025	
Date Archived	04/30/2026	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References
1. Appropriate interhospital patient transfer. American College of Emergency

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

Physicians. January 2022. Accessed December 16, 2024. www.acep.org
2. Discharges and Transfers, 42 C.F.R. § 412.4 (2022).
3. Heaton JK. EMS Inter-Facility Transport. *StatPearls*. StatPearls Publishing; 2022.
4. *Obstetric Care Consensus Number 9. Levels of Maternal Care.* American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM); 2023. Accessed December 16. 2024. www.acep.org
5. Kulshrestha A, Singh J. Inter-hospital and intra-hospital patient transfer: recent concepts. *Indian J Anaesth*. 2016;60(7):451-457. doi:10.4103/0019-5049.186012

Independent medical review – 02/21/2023